

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Thursday, January 26, 2006

9:30 AM

Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Thursday, January 26, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair, Senators Austin Allran, Janet Cowell, Charlie Dannelly, Jim Forrester, Jeanne Lucas, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Bob England, Carolyn Justice, Edd Nye, and Fred Steen. Advisory member, Senator Larry Shaw, was also present.

Kory Goldsmith, Lisa Hollowell, Ben Popkin, Shawn Parker and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She asked for a motion to approve the minutes from the December 14th meeting. Representative England made the motion and the minutes were approved.

Representative Insko stated that the purpose of the agenda was to review Developmental Disabilities (DD) services. She said that the LOC had been concentrating on looking at all of the services including the capacity to deliver and manage community services. She asked Leza Wainwright, Deputy Director of the Division on Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS), to come forward and give an overview of community services for the DD population. (See Attachment No. 2)

Ms. Wainwright began with an explanation of the topics covered in her presentation. She explained how DD was defined according to Statutes 122C-3(12a) and listed the State funded services for DD. Ms. Wainwright referenced a chart depicting the service groups, the number of clients served and the amount paid for those services for fiscal year 2005. (See Attachment No. 3) Services listed are provided to the non-Medicaid eligible population except case management, which is a Medicaid eligible service. She was asked whether everyone in the DD population is Medicaid eligible. Mark Benton from the Division of Medical Assistance said family income and assets are considered when determining Medicaid eligibility, but that once a person enters an ICF-MR facility, then the income considered is only the consumers. Family income would not be considered for a waiver slot. Ms. Wainwright then reviewed the Medicaid funded services explaining the criteria for ICF/MR eligibility and the guidelines for Home and Community Based waivers. Ms. Wainwright explained the different services available under North Carolina's CAP-MR/DD waiver, how the waiver works, and addressed the modification provision which allows a family \$15,000 for home modifications and \$15,000 for vehicle modifications over a period of 3 years.

In explaining how the CAP/MR waiver works, Ms. Wainwright said the amount of funding approved by the General Assembly dictated the number of individuals who could be served by the waiver for the upcoming year. The Division then allocates the funds to the LMEs with the projected number of people that can be served. The LMEs then project the cost of those currently on the waiver and have a prioritization process for adding people based on acuity of need, cost, and length of time service has been requested. Services are then monitored by DMH/DD/SAS and DMA. When asked how many were on the waiting list, Ms. Wainwright said a list was not maintained by the State. There are, however, spaces for 500 additional people, but no funding was available. The average cost per person, per waiver last year was \$43,000. Ms. Wainwright explained that after a person was identified as being eligible for a waiver, a person centered plan (PCP) was developed and a cost summary was completed to project the annual cost. She said the average for ICF/MR last year was \$86,000. The most expensive CAP-MR plan approved this year is \$110,000. Ms. Wainwright said LMEs were encouraged to use additional money allocated to shift those in ICF/MRs into CAP slots. Members requested data showing that information and data showing the number of people in need of service including the number of people qualified but not receiving service and those that did not qualify to receive service. Ms. Wainwright said there were individuals who would qualify for ICF/MR, but have not received a CAP slot because the Department was limited by Federal approval and by money. She also noted that ICF/MR pays for total care whereas the CAP waiver does not pay for room and board.

Ms. Wainwright then explained how the Department would address the Centers for Medicaid and Medicare (CMS) decision not to approve Developmental Therapy as a Medicaid service and also discontinue approval of Community Based Services (CBS). She said that DHHS and DMA developed a strategy to insure continued treatment for those effected by the decision from CMS. The four strategies included: 1) Increase the number served under CAP-MR/DD waiver; 2) Use new Community Support services; 3) Use Medicaid Personal Care services; and 4) Use state-funded Developmental Therapy service. She reviewed the "Decision Tree" which illustrated how case managers would take consumers who appeared to be eligible for ICF/MR care and process them in order to add them to the waiver. She announced that DHHS had submitted a technical amendment to the State Plan to add an additional 2,000 slots to the CAP-MR/DD waiver. Ms. Wainwright said the paperwork would temporarily be streamlined during this critical time in order to keep individuals from experiencing any interruption in services. She also reviewed the other strategies and said the only group the plan did not address were the children currently on the CAP-MR/DD waiver (or who will be added to the CAP-MR/DD waiver) and who are receiving CBS services in school. This is because CBS prohibits the use of CAP services in schools. Ms. Wainwright said there were 406 children that could be affected, but that DPI was sending letters to local education agencies to see that services and supports were available once CBS services are no longer available. She then reviewed the projected cost for 2006, 2007 and beyond. Of the \$5 million needed for the remainder of this year, Ms. Wainwright said funds could be identified through the Department's critical needs process within other funds appropriated to the Department. The additional \$29.5 million for 2007 and beyond did not include the cost of additional CAP waiver slots.

Members were interested in knowing what services would be lost that were once covered by CBS. Ms. Wainwright said it was primarily one-on-one service, and service delivered

by para-professional level staff which includes training and support. People impacted by the change were receiving an average of 87 hours per month, per individual at an average cost of \$15,000 per person.

Ms. Wainwright was asked if the shortage of funding for these services and others would fall on the State. She said that there was not an alternative Medicaid service other than Personal Care or Community Support and neither of those services can serve everyone who has been previously served by CBS. If these individuals are going to be served in the community, there is not an alternative to State funding.

Diann Irvin, Section Chief, Behavioral Support Services with the Department of Public Instruction said she had been working with the Division as the representative for the transition of the Service Definitions. She referenced a letter from Mary Watson, Director of the Exceptional Children Program, to the Directors of the Exceptional Children Programs. (See Attachment No. 4) The letter asked the schools to work with their local LME, and Providers, and to talk with the schools to try to identify the students affected by the changes. Once the children have been identified, the schools will have individual education program team meetings to determine what supports and needs each child will require to stay in school. Ms. Irvin said that at this point she did not know what the financial impact would be on school systems. There is funding available through Special Education, and a State Reserve Fund that is available for unusual circumstances that schools could apply for. It was suggested that DPI prepare a request for additional funding for the Short Session for the Special Education population. It was noted that the State imposed a cap on the percentage of children in the schools that can receive supplemental funding. The cap may need to be raised in light of the changes.

Next, Dave Richard, Director of the ARC of North Carolina and representing the DD Consortium, said that the Consortium responded favorably to the Department's plan to finding solutions for the needs of those with developmental disabilities. He expressed concern over the short amount of time the LMEs, Provider organizations, and State agencies had for implementation. He cautioned that while the Medicaid Personal Care Services were good for some, it was not a good crosswalk for people previously receiving help since the services could be more restrictive. Mr. Richard encouraged DPI and DHHS to work together to create contingencies to see that children continue to receive the funding needed to stay in school. He encouraged Legislators to remember the thousands of people without services who need support.

Representative Insko then asked a panel consisting of a consumer, a provider, a family member and advocates to give their experiences with community services for the DD population. Jill Hinton Keel, Director of the Autism Society of North Carolina provided an introduction. She said that reform for persons with DD should mean that a range of supports are available at the community level to support individuals whether minimal or significant and reform should ensure that the system is structured in a way that promotes person-centered planning. The DD provider capacity issue is different from the MH/SA system in terms of having providers available in the community. The capacity issue is more related to how funding is structured and the relationship with providers. She suggested that the State and LMEs could develop more expertise in DD and implement policies to support the delivery of services; keep accurate data of waiting lists and

tracking outcomes; ensure consistency statewide in terms of requirements and regulations; and ensure an effective case-management system.

Kathy Bryan, Director of Orange Enterprises told the group that her remarks represented many agencies. (See Attachment No. 5) She commented that DD's presence in the Division had been greatly reduced but good things had happened like best practice and the expectations that North Carolina will deinstitutionalize and existing agencies were moving towards community based services. She expressed concern raised was that DD providers were expected to develop services that follow the provision of and reporting mode of the medically based models for mental health and substance abuse. She said it was critical that provider agencies be funded at a level where they could function and that they should be paid on time. Other difficulties Ms. Bryan mentioned included the issue of different interpretation of rules, service definitions, quality standards, documentation requirements, billing requirements and contracts. She said adequate funding was needed as well as a statewide uniform software system and a mechanism to ensure funding allocated for specific services was actually distributed for those services.

Next, Laura Gorycki, an advocate for individuals and families from the Enrichment Center in Winston-Salem, said reform should always focus on community inclusion and habilitative services. She said that CBS worked well with the adult population by integrating them into the community, so it is important to have stability in the community based programs. She also said that some people had been waiting for CAP services since 2000. She said the community needs to be educated about social inclusion and programs need to be developed to address the stigma and barriers people with DD face. Ms. Gorycki said there needed to be a way to identify methods to continue services to children without any gaps in those services.

Jim Woolsey spoke as a parent concerned about future services for his developmentally disabled son. He said he found that services were uneven and turnover high at the local care provider level due to poor wages. He said families need more people who can offer more hands-on monitoring of the quality of life for the disabled population. Mr. Woolsey said the State should establish and maintain adequate waiting lists since that is the only way to monitor how large the problem is. He suggested that the LMEs needed more time to make major changes and that Providers should be paid on time during the March conversion. He suggested that one item that needed attention was the question of what happens to an aging group home resident who wants to retire. Under current rules, group home residents must be employed to remain in the group home.

Rose Reaves, a consumer, came with a prepared statement read by Jane Phillips. She spoke of the supports and services she receives that allow her to live an independent life. Ms. Reaves said she led a very active life in her community. She is an active church member, a volunteer, a member of several boards, and has received city and State awards. She also told of her fears that funding cuts to services that would change her life drastically. She said that she had a job that was very important to her but was only able to complete her duties with the assistance of her job coach. She said that without CBS she would lose her job and the assistance of a support staff that made it possible for her to live independently in her home. She said she was thankful for the opportunity to speak not only for herself, but for others who had achieved independent.

After lunch, Mike Moseley, Director of the Division of MHDDSAS addressed the committee to give an update on the CMS approval of the new Service Definitions. He said that with the approval of the State Plan Amendment for mental health and substance abuse services in late December, the Department was seeking to implement the new services on March 20, 2006. He explained the scope of certain services in three areas not approved by CMS. The first was the facility based crisis services for adults and children. CMS would not approve the service for children. An alternative would be a psychiatric rehabilitation treatment facility. CMS also imposed a 30-day restriction per consumer, per year for those served in facility-based crisis in residential services. Mr. Moseley said a separate State Plan Amendment had been approved by CMS to rebase the psychiatric inpatient rates for hospitals which will increase revenue for hospitals. Mobile crisis units will also be important in helping prevent consumers from needing a higher level of care.

Another service definition affected by CMS was the Substance Abuse Medically Monitored treatment. It was approved for adults but not children. This service would have offered more Medicaid support for substance abuse patients, primarily women and children. With denial, housing through licensed halfway houses will continue to be used with Medicaid helping to pay for treatment.

The final item CMS imposed was a restriction on children receiving residential day treatment services by saying children can not also receive onsite day treatment service. CMS believes that if a child is in a residential treatment program, the child would already be receiving treatment as a part of the dollars paid by Medicaid to support that particular service.

Mr. Moseley said that with the approval of the State Plan amendment, the State would be able to begin providing the full range of services to individuals with substance abuse issues, according to the American Society for Addictive Medicine. He also said that the Department had not yet received a response from CMS to a State Plan amendment for Targeted Case Management Services for individuals with DD. He also mentioned that the Department had received positive word on the amendment on the Inpatient Psychiatric Rebasing. The Department submitted a request for an expedited review by CMS for approval to expand the number of slots in the CAP-MR/DD waiver in order to address the CBS issue. Mr. Moseley said a submission date had not yet been determined for the Self Directed Support waiver for consumers with DD.

Mr. Moseley briefly covered the Provider endorsement process. He said those providers who in the past provided Enhanced Benefits Services, would be able to directly enroll with DMA effective March 20. A new mechanism in place will allow the LME to first endorse a provider agency before that agency can apply for and receive enrollment within the Medicaid agency. This is to ensure the provider has the credentialed staff, and that licenses are in place for the applicable service. Based on the review by the LME, the provider agency could then enroll with the Medicaid agency. He then reviewed the steps for the endorsement process. Mr. Moseley said the provider could continue to bill through the LME until they are enrolled in the Medicaid program. The DMA process will take 3 to 6 weeks to process. Since the State Plan amendment was approved, 646 providers have been endorsed statewide. Training in the new service definitions has been on going and will continue for service providers.

Continuing, Mr. Moseley gave an update on regional Utilization Review (UR) and on Screening, Triage and Referral (STR). He announced that the decision had not yet been made to determine which LMEs would be conducting regional UR and STR for after hours and weekends but the announcement would be made soon. Mr. Moseley referenced a map depicting suggested LME groupings provided by the NC Council of Community Programs. (See Attachment No. 6) He said that if multiple LMEs within a group wanted to perform the functions, they were told to determine among themselves who would apply. The applications were then received and reviewed, on site visits conducted and the information compiled would be reviewed with the Secretary. He said the daytime STR would continue to be retained by each LME and after hours, weekends and holiday STR would be conducted by the lead LME for each group. The estimated net cost savings would be \$14.5 million in State dollars. It was suggested that the LMEs might respond on the impact of staffing and how it affects the clientele in the community.

Leza Wainwright addressed the requirements of the use of non-Medicaid funds for services to the target population across all three disability groups. Ms. Wainwright explained how funding changed in the early 1990's to a Unit Cost Reimbursement System (UCR). UCR is money paid out for services at the established rate for that service. Non-UCR money is paid out based on expenditures. She reviewed a chart showing State and State allocated Federal funding going to Community Program Services. (See Attachment No. 7) While reviewing the Substance Abuse and the Mental Health Block Grants, she referenced a chart detailing the restrictions on the use of the federally allocated funds. (See Attachment No. 8) An outline of services provided last year were listed showing State Federally funded services. (See Attachment No. 9) Ms. Wainwright then reviewed a modified chart of the Durham Center, which received \$10.2 million from the State in non-Medicaid dollars for the targeted population. (See Attachment No. 10) She explained the difference in committed funds and those that were discretionary. Ms. Wainwright said that those funds labeled "discretionary" were there to be used by choice to provide services or to use flexibly for some different service.

The meeting adjourned at 3:15 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant